Georgia Department of Community Health

State Health Benefit Plan

Dependent Student Status Information

(For Dependent Students Age 19 to 26 Only)

Return Form to:
State Health Benefit Plan
Eligibility Section
P. O. Box 38342
Atlanta, GA 30334-0342

I. Employee/Member Information

Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Last Name | First | Initial

Apartment/Box/Route

Street Address

City, State | Zip Code (5-digit + 4-digit)

County of Residence | Daytime Telephone Number ( ) Area Code

IMPORTANT: Both Sections I and II must be completed and Section III must be signed and dated before student coverage can be extended.

II. Dependent Student Information

Student's Social Security Number ☐☐☐ – ☐☐ – ☐☐☐☐

Last Name | First | Initial

Sex	Date of Birth			Marital Status
	Month	Day	Year	
☐ Male				☐ Single
☐ Female				☐ Married
				☐ Divorced

Expected Graduation Date

What is the anticipated (or actual) date of graduation for the current program or plan of instruction?	Month	Day	Year

Is it the student's intention that he/she will attend an accredited school full-time next quarter/semester? Yes ☐ No ☐

Is the dependent employed full-time? Yes ☐ No ☐

If yes, is health benefit coverage provided through the employer? Yes ☐ No ☐

Conditions and Instructions (Read Before Completing This Form)

Requirements for student coverage. The dependent student must be:

(1) age nineteen (19) through twenty-five (25);
(2) in regular full-time attendance at an accredited school (the number of hours required for full-time status is defined by the individual school);
(3) not employed in a benefits eligible position; and,
(4) never married and otherwise eligible for dependent coverage.

Required Documentation. Dependent student status must be documented by a Certification Letter which includes:

(1) the date(s) of enrollment for both current and previous quarters/semesters;
(2) the number of credit hours taken each period;
(3) the enrollment status for each period; and,
(4) the expected date of graduation.

Note: Letters of acceptance, student ID cards, class schedules, and billing/payment invoices/recepits are not valid certification letters.

Termination of student coverage. Coverage for a dependent student ends/terminates:

(1) at the end of the month in which the student completes academic requirements for graduation; or,
(2) upon ceasing full-time attendance unless the student has attended the previous three consecutive quarters (or two semesters) and intends to return following an absence of one quarter (or one semester).

Instructions. Complete the Employee/Member and Dependent information requested above. Read the Certification Statement below, then sign and date this form. Staple the Certification letter from the Registrar's office to the form and return the form to the address shown above. Please keep a copy of this information in your files. Prompt updates will prevent a delay in claim processing or verification of coverage. The coverage expiration date printed on the Plan identification card or HMO notification is calculated with the assumption that the dependent will remain a full-time student through that date. If the dependent does not remain a full-time student, the member must notify the SHBP Eligibility Section (at 404-656-6322, or 1-800-610-1863) immediately.

III. Certification by Employee/Member

I certify that the information on this form is correct to the best of my knowledge and belief. I understand that inaccurate or incorrect information may result in cancellation of health coverage for this dependent. I further understand that it is my responsibility to notify the SHBP of the student status for this dependent, and that coverage will be provided only for the period of full-time attendance.

X _____ _____

Signature of Member/Employee | Date